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GUY P. JONES
EDITOR

Plan to Reduce Maternal Mortality.

A national program for the prevention of maternal mortality and morbidity throughout the United States is outlined by the Children's Bureau of the U. S. Department of Labor in a report on maternal mortality made public today.

This report, the work of Dr. Robert Morse Woodbury, formerly director of statistical research for the Children's Bureau, brings together and analyzes all available material both American and foreign on deaths of mothers during childbirth and is considered one of the most important pieces of recent research in the field of the bureau's work. Children's Bureau officials feel that it indicates the necessary emphasis during the coming decade in the effort to reduce deaths among both babies and mothers.

HIGH MATERNAL MORTALITY RATES IN THE UNITED STATES.

Maternal mortality rates in the United States are today among the highest in the civilized world, and but a slight decrease in these rates has occurred since the beginning of the present century, Dr. Woodbury's report states. The significance of these facts from a national point of view is found not only in the loss which this means of the lives of women presumably at their prime, but also in the far-reaching effect of maternal mortality on the infant death rate. Dr. Woodbury points out:

"A very considerable proportion of all deaths of infants under 1 year of age occur during the first month of life from causes which have their origin in the care and condition of mothers during pregnancy and confinement. In the United States as a whole it may be estimated that approximately 100,000 deaths of infants under 1 month of age occur every year. Reduction in the mortality from these causes depends upon improvement and extension of facilities for prenatal, confinement, and postnatal care. It may also be estimated that at least 100,000 stillbirths occur each year. The same measures which will safeguard the lives and health of mothers during pregnancy and labor will also tend to reduce the stillbirth and neonatal mortality rates."

Dr. Woodbury estimates the total annual number of maternal deaths in the United States on the basis of 1921 birth-registration area statistics to be 18,281. However, a careful survey of sources of error in certifications of death throughout the area leads him to the conclusion that the true number of maternal deaths is probably as much as 12 per cent in excess of those reported, making an estimated yearly death toll of more than 20,000 women. The maternal mortality rate in 1921 was 6.8 per 1000 live births. The provisional 1924 rate was 6.6.

TREND OF MATERNAL MORTALITY SINCE 1900.

Figures showing the trend of maternal mortality over a 22-year period in the United States, if accepted at their face value, would show an increase in the maternal death rate from 13.3 per 100,000 population in 1900 to 16.9 in 1921, according to the report. However, analysis of various factors affecting these statistics, particularly the campaign for better certification of the causes of death during recent years, would indicate in reality a "very slightly downward trend" since 1900.

Comparison of the United States rates with those of other countries shows that the United States ranks among those having the highest rates, such as New Zealand and Chile. Among the countries having rates less than half that of the United States are Denmark, Finland, Italy, Japan, the Netherlands, Norway, Sweden and Uruguay.

CAUSES OF MATERNAL MORTALITY.

Analysis of the causes of maternal deaths in this country shows that the most important single cause is puerperal septicemia, due to infection resulting from lack of surgical cleanliness and almost 100 per cent preventable through careful asepis. Two-fifths of the maternal deaths in the death registration area of 1921 were due to septicemia. Among other causes, puerperal albuminuria and convulsions was most important, contributing over one-fourth of the deaths. This cause is preventable through competent medical care during the prenatal and confinement period. Other causes of death included accidents of pregnancy, hemorrhage, accidents of labor.

Factors effecting the risk of maternal death are analyzed by the report. Statistics indicate that the risk of death to the mother is greater in the case of plural than of single births and greater for mothers under 15 and over 45 years of age than to those between 15 and 45. The lowest mortality is found among mothers between 20 and 24. Maternal mortality, like infant mortality, is higher in first births than in second, third or fourth births, lowest of all for third births, and gradually higher with each birth after the third until the maximum death rate is reached with the eighth and later children.

POVERTY AN IMPORTANT FACTOR.

As with infant mortality also, poverty is found to be an important factor in maternal death rates, these increasing as the husband's earnings fall, probably because of lack of proper facilities and adequate care for the poor mother. Color and nationality are also important factors in maternal mortality. In the birth-registration area for 1921 the negro maternal death rate was 67 per cent higher than the white rate. On the other hand, the rate for foreign-born white mothers was slightly lower than that for native white mothers. Among the nationalities included in the foreign-born white group, the rate was lowest for mothers born in Russia, and next to lowest for mothers born in Italy. At the other extreme were the rates for mothers born in Ireland, Great Britain, Canada, Hungary, and Germany. The racial stocks represented in the nationalities for which the rates were highest are, it is pointed out, those which principally compose the native white population.

CITY AND COUNTRY RATES.

Cities showed a higher maternal mortality rate than rural districts in the United States, according to the 1921 figures, but to some extent this difference is to be accounted for by the fact that many of the more difficult or complicated cases are brought from rural regions into cities in order to secure the better medical and hospital facilities of the city. The classification of cities into groups according to size brings out the interesting fact that the highest mortality from puerperal septicemia was found not in the large centers but in the group of cities which had populations of 25,000 to 50,000. Except for the rural areas the largest cities had the lowest rate.

MATERNAL MORTALITY LARGELY PREVENTABLE.

The preventability of maternal mortality is considered in the light of the analysis of causes and causal factors, by the Children's Bureau report.

"Almost all the mortality from puerperal septicemia is preventable," the report states. "Puerperal septicemia is infectious in origin, and its prevention depends upon the rigorous observance of asepsis. The Australian committee appointed to study the causes of death and invalidity in the commonwealth states: 'Puerperal septicemia is probably the greatest reproach which any civilized nation can by its own negligence offer to itself. It can be prevented by a degree of care which is not excessive or meticulous, requiring only ordinary intelligence and some careful training.'"

RECOMMENDATIONS FOR PREVENTION.

For the prevention of the most important causes of maternal deaths the essential recommendations by the bureau are: Effective supervision by a public-health agency over hospitals and over the training and admittance to practice of physicians, midwives, and nurses, and the requirement that all cases must be reported, as in the case of other infectious diseases. The experience of Norway is cited. In that country puerperal septicemia was early made a reportable disease and measures of public control instituted. The result has been the elimination of four-fifths of the cases of the disease and the virtual elimination of deaths from it. Similar striking decreases have occurred in England and Wales and the Netherlands. Of special interest as a demonstration of what can be done in a large city in this country are figures from New York city showing a steady drop in the rate from 4.1 in 1900 to 2.5 in 1921, a rate still considerably higher than those for the countries mentioned, however.

Other puerperal causes of death may be prevented in a large proportion of cases by proper prenatal and natal care of the mother. Studies in this country, including the demonstration in New York city of the Maternity Center Association and the Henry Street Settlement, as well as evidence of physicians and public-health authorities here and abroad, have shown the value of competent medical supervision in the reduction of rates from these causes.

The problem of prevention is, therefore, summarized by the Children's Bureau report as that of insuring to every mother skilled assistance before and during childbirth. The question of the extent to which mothers in the United States are today receiving such care is discussed on the basis of the scattered information available. In Baltimore, in 1915, with an excellent medical school and hospital and well-developed clinics, nearly half of all married mothers having babies during that year had no medical prenatal care of any kind and only 5 per cent had received care that could be classified as Grade A. In Gary, Ind., in 1916, 70 per cent of the mothers had not received any medical prenatal care. In rural districts, studies indicate on the whole an even smaller proportion of mothers receiving prenatal care. Although these studies, made by the Children's Bureau, relate to a period from four to eight years ago, and the campaign of popular education on the subject as well as the establishment of prenatal clinics has probably increased somewhat the percentages of mothers receiving adequate medical attention during the period before the birth of their babies, even yet the proportion is, according to the Children's Bureau, probably very small. Attendance by physicians at the birth of the baby is reported for larger proportions of mothers, varying from 97 per cent in Nebraska to 51 per cent in Louisiana. Evidence is not available, however, as to the qualifications of the attendants at birth. Postnatal care is reported on for the cities of Baltimore and Gary and shows that a large proportion of the mothers did not receive adequate supervision after birth.

A PREVENTIVE PROGRAM.

The preventive program suggested by the report, in its main outline, follows:

(1) Regulation of the practice of obstetrics, by requiring a license to practice from both physicians and midwives, by establishing minimum requirements for obtaining such a license, and by defining and prescribing penalties for malpractice.

(2) Regulation of public and private hospitals and maternity homes through legal provisions governing the establishment of such institutions and requiring that they be licensed and subject to inspection.

(3) Legislation for the control of venereal diseases including the making of these diseases reportable.

(4) Requiring that puerperal septicemia be made reportable, as is now the case in a number of states.

(5) Provision through governmental or public sources of better facilities for training medical and nursing personnel and more adequate clinics, hospitals, and maternity homes.

(6) Subsidies in aid of state or local activities by federal or state governments, as in the United States during the past four years through the Maternity and Infancy Act.

(7) Educational work directed toward informing mothers of the need of adequate maternity care.

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When we consider that more hospital beds are devoted to care of mental patients than to all other forms of sickness combined; that there are large armies of psycho-neurotics who are living on half-time and who are definite psychiatric problems; and finally when we consider behavior deviations and the tremendous human wastage in our prisons and reformatories—we see the problems which challenge psychiatry to develop an interest in the positive health program.—Dr. Frederick H. Allen.

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Equally important, and interrelated with the physical needs, are the emotional needs of childhood, such as the need for wise love and understanding, for protection against such psychic blights as fear, and the abuse of primitive emotions such as anger. Only thus may we have a race of children free in spirit and strong enough to carry on the highest ideals of our civilization. Such education for constructive freedom necessitates homes and schools flooded with fresh air and sunlight, with ample play space, with serene and well qualified parents and teachers.—Herbert Hoover.

MORBIDITY.*

Diphtheria.

87 cases of diphtheria have been reported as follows: Oakland 2, Fresno 2, Los Angeles County 15, Glendale 1, Huntington Park 1, Long Beach 1, Los Angeles 22, Willets 1, Salinas 1, Orange County 1, Fullerton 2, LaHabra 1, Sacramento 5, San Diego 7, San Joaquin County 1, San Francisco 18, Santa Clara County 2, San Jose 1, Healdsburg 1, Corning 1, Fillmore 1.

Measles.

141 cases of measles have been reported as follows: Alameda County 3, Alameda 11, Berkeley 13, Oakland 41, Calaveras County 1, Los Angeles County 1, Pasadena 1, Los Angeles 3, Monterey County 5, Carmel 12, San Francisco 30, San Joaquin County 3, Manteca 1, San Bruno 1, San Mateo 1, Santa Maria 1, Santa Clara County 5, San Jose 6, Sunnyvale 2.

Scarlet Fever.

63 cases of scarlet fever have been reported as follows: Berkeley 2, Oakland 1, Gridley 1, Fresno County 1, El Segundo 1, Long Beach 4, Los Angeles 16, Pasadena 1, Pomona 1, Hawthorne 2, Orange County 1, Fullerton 1, Orange 1, Riverside County 2, Riverside 1, Sacramento 1, Ontario 1, San Bernardino 1, San Diego 5, San Francisco 5, Manteca 2, Stockton 4, San Luis Obispo County 1, San Jose 1, Sonoma County 1, Healdsburg 3, Tulare County 2.

Smallpox.

7 cases of smallpox have been reported as follows: Oakland 3, Glendale 2, Los Angeles 1, Tulare County 1.

Typhoid Fever.

20 cases of typhoid fever have been reported as follows: Los Angeles County 3, Huntington Beach 1, Newport Beach 1, Sacramento County 1, San Joaquin County 1, Manteca 1, Stanislaus County 1, Tulare County 1, San Francisco 1, Los Angeles 3, Pittsburg 1, California 5.

Whooping Cough.

40 cases of whooping cough have been reported as follows: Alameda 1, Berkeley 7, Oakland 11, Piedmont 3, Alhambra 1, El Monte 2, Long Beach 1, Los Angeles 6, Pasadena 3, Monrovia 2, San Bernardino 1, San Francisco 2.

Epidemic Meningitis.

San Diego County and Long Beach each reported a case of epidemic meningitis.

Poliomyelitis.

4 cases of poliomyelitis have been reported as follows: Long Beach 1, Paso Robles 1, San Diego 1, Redwood City 1.

Rabies (Human).

Los Angeles County reported one case of human rabies.

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*From reports received on September 6 and 7 for week ending September 4.

COMMUNICABLE DISEASE REPORT.

	1926				1925			
	Week ending			Reports for week ending Sept. 4 received by Sept. 7	Week ending			Reports for week ending Sept. 5 received by Sept. 8
	Aug. 14	Aug. 21	Aug. 28		Aug. 15	Aug. 22	Aug. 29	
Anthrax	0	0	0	0	0	0	0	0
Botulism	1	0	0	0	0	0	0	0
Chickenpox	32	57	33	29	23	25	38	20
Diphtheria	58	47	80	87	71	77	61	51
Dysentery, Bacillary	1	2	6	0	2	1	1	2
Encephalitis, Epidemic	0	1	3	0	2	1	1	1
Gonococcus Infection	224	94	100	153	114	63	105	105
Influenza	3	5	6	6	7	6	8	2
Jaundice, Epidemic	1	0	0	0	1	0	0	0
Leprosy	1	0	0	0	1	0	1	0
Malaria	2	2	12	3	0	0	4	7
Measles	104	86	149	141	20	9	14	10
Meningitis, Epidemic	4	1	1	2	1	4	2	2
Mumps	46	51	73	60	77	49	39	36
Paratyphoid Fever	1	0	0	3	3	1	0	2
Pneumonia, Lobar	25	20	57	19	36	30	20	24
Poliomeyeltis	4	7	3	4	44	38	44	24
Rabies (animal)	5	4	7	6	6	1	3	4
Rabies (human)	1	0	0	1	0	0	0	0
Rocky Mt. Spotted Fever	0	0	0	0	0	0	0	0
Scarlet Fever	41	49	68	63	46	39	41	27
Smallpox	20	5	4	7	42	31	14	17
Syphilis	144	97	68	146	105	80	81	198
Tetanus	1	1	3	0	2	3	1	1
Trachoma	4	1	7	1	1	5	5	2
Trichinosis	0	0	0	0	0	0	0	0
Tuberculosis	155	193	173	163	245	141	186	131
Typhoid Fever	30	28	31	20	39	46	32	22
Typhus Fever	0	0	0	0	0	0	0	0
Whooping Cough	68	26	61	40	182	134	94	67
Totals	976	777	945	954	1,070	784	795	755

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